DUAL DIAGNOSIS
Resource Kit

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Drug and Alcohol Office
Government of Western Australia

Department of Health
Mental Health Division

DUAL DIAGNOSIS RESOURCE KIT

Many mental health and alcohol and drug services work collaboratively across the sectors. The development of this resource kit was based on information gleaned from services themselves and source materials that are already in use across the sectors.

CONTENTS:

- Background Information
  Drawn from *The Management of People with Co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines*, NSW Health Department 2000 and including a linked service check list based on *Standards for Mental Health Services: Alcohol and drug Misuse and Mental Health Co-morbidity*. The Alcohol and drug Misuse Advisory Service, London UK 2001.

- Template Memorandum of Understanding between local services

- Sample forms for referral and joint case conference

- List of suitable screening tools

The material in this resource kit is available on the Drug and Alcohol Office website at http://www.dao.health.wa.gov.au/

DUAL DIAGNOSIS
BACKGROUND INFORMATION

DESCRIPTION OF CLIENTS AND SYSTEM RESPONSIBILITIES

The information in this section has been taken from *The Management of People with Co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines* which were developed by the NSW Health Department. They provide information that will assist agencies working together to provide services to comorbid patients [1]

Evidence now suggests that drug and/or alcohol misuse among patients with mental disorders must be considered as usual rather than exceptional. People with comorbidity problems present on a continuum of presenting problems. Those at either end of the continuum e.g. predominantly mental health or predominantly alcohol and drug use can and should access the appropriate services. It is those in the middle that may need coordinated service delivery.

- People **severely disabled by mental health problems and disorders and adversely affected by problematic alcohol and drug use disorders** would generally be the primary responsibility of mental health services with extra support and assistance provided by drug and alcohol services.

- People **severely disabled by alcohol and drug use disorders and adversely affected by mental health problems and disorders** would generally be the responsibility of drug and alcohol services with input from specialist mental health services as required.

- People **severely disabled by comorbid mental health and alcohol and drug use disorders** will require a coordinated, integrated approach by both mental health and drug and alcohol services. Joint case management or an identified clinician with responsibility as care coordinator from the service most able to meet the current needs of the client will ensure continuum of care.

- People **mildly to moderately disabled by comorbid mental health and alcohol and drug use disorders** may access both mental health and drug and alcohol services from time to time, but the primary care provider would in most cases be the general practitioner. At the milder end of the spectrum, this group represents the majority of people affected by dual disorders.

[1] The Management of People with Co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines. NSW Health Department 2000

DUAL DISORDER PRESENTATIONS

Mental Health Services
Primarily responsible for people severely disabled by current mental health problems and disorders and adversely affected by alcohol and drug use disorders.

Drug and alcohol Services
Primarily responsible for people severely disabled by current alcohol and drug use disorders and adversely affected by mental health problems and disorders.

Mental Health and Drug and Alcohol Services
Shared responsibility for people severely disabled by comorbid disorders where both disorders are treated concurrently in the service best placed to meet the clients needs.

General Practitioners
Primarily responsible for people with mild to moderate comorbid disorders but with access to expertise from specialist mental health and drug and alcohol services as required.

INTEGRATED CARE

Interagency links and partnerships
To achieve optimal health outcomes, links to specialist and mainstream services are required. These may involve links between specialist services such as mental health and drug and alcohol with a Memoranda of Understanding or service agreement. They may also involve shared-care arrangements – for instance between these specialist services and general practitioners or between health services and non-government organisations. Understanding how and who to contact in other health and related organisations should be established as core, every day business. Resource manuals and the development of clinical and management information systems, would help improve access to and knowledge of other service providers.

Joint assessment and co-management
The sharing of expertise, in joint assessments and co-management are two strategies to ensure better identification, treatment and care coordination. Collaborating in joint approaches should be two-way, mutually beneficial and focused on delivering comprehensive health care. This process would improve consumer outcomes, help the development of ongoing partnerships and increase the knowledge and skills of the participating clinicians.

Formal process of networking and liaison
To better integrate service provision and reduce the number of people ‘falling through the gaps’, formal networks and regular liaison between primary care providers across service sectors should be established. Open invitation and access to special interest groups, in-service education sessions and journal clubs, could be extended to cross-sector and related health services. Regular attendance by relevant clinical staff in case conferences and related meetings would further establish links and partnerships.

CONTINUITY OF CARE

Case reviews

Attendance by relevant mental health and drug and alcohol clinicians in case reviews and conferences should be a regular and continuous process. To further safeguard continuity of care and reduce the number of people caught between service delivery gaps, the involvement of general practitioners and relevant staff from other agencies is recommended. Including consumers and their carers in these sessions may be appropriate at times and should be considered. Clinical supervision from a more experienced colleague could help direct treatment strategies and provide the necessary ongoing support and guidance for primary care providers.

Identified clinical care coordinator/case manager

Continuity of care for ongoing problems is better managed when the responsibility for ongoing support and treatment is identified to a particular service and person. This should be negotiated on a needs basis and where possible provided in ways which meet the client's current needs. In the majority of instances to ensure continuity of care, it will be important that the general practitioner has the primary role.

LINKED SERVICES CHECK LIST

The following standards were developed in the UK [2] and may provide some guidance in the form of a check list to ensure that practices are in place at that will promote linked service delivery.

Check list – Liaison

- There are mechanisms for liaison between mental health and alcohol and drug services, regardless of what model of service delivery exists locally.
- There are named staff responsibility for liaison.
- Resources and staff time are allocated for the development of liaison.
- There are properly defined channels of communication on a regular basis between alcohol and drug-misuse treatment and mental health services.
- Mental health and alcohol and drug-misuse services establish a common language for successful communication.
- There are management policies and protocols for working with people with co-morbidity shared by mental health and specialist alcohol and drug-misuse services in the statutory and voluntary sectors.
- Accessibility to staff (by staff) at many levels.
- Regular case conferences and where relevant there are joint case management meetings.
- Joint training events and programs (to include NGO agencies where appropriate).
- There are named lead professionals for contact between mental health services and drug treatment interventions

Joint protocols are drawn up with the agencies involved.

- There are shared protocols between mental health and specialist alcohol and drug-misuse organisations in the statutory and voluntary sectors.
- Shared protocols on agreed screening and assessment procedures.
- Shared protocols deal with referral procedures.
- Shared protocols deal with sharing information on clients.
- Shared protocols deal with an agreed management of patients.

To assist in the development of shared practices the following “tool kit” has been developed.

[2] Standards for Mental Health Services: Alcohol and drug Misuse and Mental Health Co-morbidity. The Alcohol and drug Misuse Advisory Service, London UK 2001

Template

MEMORANDUM OF UNDERSTANDING

Between

Name of agency _____

and

Name of agency _____

This Memorandum of Understanding is dated 2006

1. BACKGROUND

The Mental Health Division, the Drug and Alcohol Office together with the non-government peak organisations, WA Network of Alcohol and Drug Agencies and WA Association for Mental Health, have endorsed the development of formal linkages between local alcohol and drug and mental health service to assist coordination and shared care practices for the management of clients with alcohol and drug and mental health comorbidities.

2. PURPOSE

The purpose of this Memorandum of Understanding (MOU) is to support liaison, communication, consultation and shared care practices between local alcohol and drug and mental health agencies.

3. PRINCIPLES

- Provide optimal continuity of care for people accessing the services.
- Client needs should guide service interactions and operations.
- Issues that arise as the MOU is developed and implemented will be approached as matters to be resolved rather than as barriers.

EXAMPLES OF INFORMATION THAT CAN BE INCLUDED:

4. BASIS OF PARTNERSHIP

- A clear statement that the agencies agree to enter into a partnership.
- The services that each agency will contribute to the partnership.
- The period of operation of the MOU, a specified review period and length of notice required to leave the partnership.

5. DESCRIPTION OF SERVICES

This may include details about:

- Priority groups
- Inclusion/exclusion criteria
- Type of staff and their availability e.g. Doctor may only be made available for referred patients one day a week
- Ability to assess and manage risk issues.

6. LIAISON AND CONSULTATION

- Mechanisms for ongoing liaison, e.g. key worker positions, shared learning activities, team meetings and strategic planning.
- Procedures for secondary consultation (advice from one service to the other re client management).

7. REFERRALS

Identify pathways that patients can be referred between the agencies. This should include:

- Agreed referral forms
- Key workers/positions that will provide liaison
- Consent forms for the exchange of information signed by the patient
- Timelines for the forwarding of relevant background information.

It may also be useful to develop guidelines for referral that will ensure that referrals are appropriate.

8. INTEGRATED CARE PROTOCOLS

- Outline of the case management model to be employed.
- Specific processes e.g. joint assessment, shared care and case review

The MOU should include basic expectations in the case management of a client including:

- Informing the referring party of the outcome of the referral
- Informing the referring party of discharge from treatment
- Informing the referring party of significant events.

9. CONFIDENTIALITY AND PRIVACY

For the purposes of this Memorandum of Understanding:

> ‘Confidential Information’ means all information which is not in the public domain and which is reasonably regarded by a Party as confidential;
>
> ‘Party’ means a party to this Memorandum of Understanding; and
>
> ‘Parties’ means xxxx and xxxxx

Both xxx and xxxx agree to hold all confidential information in confidence for each other and will not directly or indirectly at any time during this MOU or after

the termination or expiry of this MOU use any confidential information or disclose any confidential information to any third party except if the use or disclosure:

(a) relates to information already within the public domain, other than by virtue of a breach of this Clause by the disclosing Party;
(b) is required by law or by any competent authority having jurisdiction over a Party; or
(c) is made with the prior written consent of the other party.

Both xxxx and xxx hereby acknowledge that where they are bound by the provisions of the Privacy Act 1988 and they handle any Personal Information under this agreement, they shall comply with their obligations under that act including, without limitation, how they collect, use and disclose the Personal Information. Further, where either Party is not an Organisation (as defined in the Privacy Act 1988) that Party hereby agrees to comply with the provisions of the Privacy Act 1988 as if it was such an Organisation.

10. MAINTENANCE OF DATA/EVALUATION

- What data will be collected and by whom.
- Responsibility for the collation of data and any report preparation.
- Clarify how the joint activities will be evaluated.

11. LEGAL RESPONSIBILITIES

The MOU does not create legally enforceable obligations on the parties. The parties note that staff remain the employees of their employing agencies at all times. Neither party will be liable to the other in respect to any loss or damage or injury suffered by their staff while on each others premises expect where such loss, damage or injury is as a result of negligence. All parties will remain responsible for their own insurance.

12. COSTS

There will be no additional financial costs for either party.

13. DISPUTE RESOLUTION

If a question, difference or dispute arises at any time between the Parties concerning this Memorandum of Understanding or the rights, duties or liabilities of any Party under this Memorandum of Understanding (“Dispute”) then the relevant xxx manager & xxxx manager will negotiate in good faith to resolve the dispute.

14. TERM

This agreement is for the period commencing on xxxxxxx and expiring on xxxxxxx unless earlier terminated in accordance with this Memorandum of Understanding.

15. TERMINATION

Either Party may terminate this Memorandum of Understanding by giving 30 days written notice to the other Party.

Executed as a Memorandum of Understanding

SIGNED ON BEHALF OF XXXXXXX

SIGNATURE: .....

NAME: .....

TITLE: .....

DATE: .....

SIGNED ON BEHALF OF XXXXXX

SIGNATURE: .....

NAME: .....

TITLE: .....

DATE: .....

CLIENT REFERRAL FORM[3]

(To transfer a client from one agency to another agency)

AGENCY DETAILS

Date of Referral		
Referring Agency		
Contact Person		
Contact Phone Number	Telephone	Mobile

CLIENT DETAILS

Name			Date of Birth
Address			
Phone Numbers	Home	Work	Mobile

Reason for Referral

_____
_____
_____
_____

Current Drug Use

_____
_____
_____
_____

[3] This form is based on a referral form supplied by the Palmerston Association as part of the linkages survey.

Brief Drug Use History

Mental Health Issues & Relationship to Alcohol and Drug Use (if applicable)

Other Issues of Concern

Treatment History

Reason for Referral

Please Indicate Which Service You Are Requesting

CASE CONFERENCE FORM[4]

CLIENT DETAILS

Name			Date of Birth
Address			
Phone Numbers	Home	Work	Mobile

Requesting Agency	Case Manager

Reason for Case Conference

(Include details of key mental health and alcohol and drug issues)

Case Conference Participants

Name of service provider	Care provided to client	Contact details

Patient agreement:
The purpose of the case conference has been explained to me and I give my permission for the case conference to proceed and for details of my history to be discussed with the listed participants. I have outlined any medical history or other details I wish to have withheld. All information will be confidential.

Signature:_____ Date:_____

[4] This form has been adapted from a form developed by the Whitehorse Division of General Practice, Victoria

Case Conference Outcomes and Participant Responsibilities

Current problem/ need	Goal	Planned action/tasks	Service provider responsible

Patient agreement to Case Conference Goals

I understand the above case conference recommendations and agree to the outlined goals:

Signature:_____ Date:_____

Further Case Conference required:	No ☐ Yes ☐
Review date:	____/____/____
Case Conference summary forwarded to patient and participants on:	____/____/____

SCREENING TOOLS

Alcohol and drug agencies are good at assessing alcohol and drug problems and mental health agencies have the required knowledge and skills to assess mental health problems. When assessing the needs of patients with comorbidities the needs for AOD and MH agencies are quite different. There is also no expectation that equal levels of skill are required across both areas. Screening tools or assessment processes will indicate that a patient has a comorbidity issue that requires further or specialist attention.

This following list provides the names of tools that may be useful in the assessment of dual diagnosis patients. Copies of these screening tools are available at http://lib.adai.washington.edu/dbtw-wpd/exec/dbtwpub.dll

Screening tools	**Located at:**
Combined	
Mentally Ill Drug & Alcohol Screening MIDAS	www.ohiosamiccoe.cwru.edu/library/media/clinicaltool_midas.pdf
Substance Use	
Brown Two Item Screen	http://www.familypractice.com/journal/abfpjournal_frame.htm
CAGE/CAGE-AID	http://lib.adai.washington.edu/instruments/
TWEAK	http://lib.adai.washington.edu/instruments/
T-ACE	http://lib.adai.washington.edu/instruments/
Alcohol Dependence Scale ADS	http://lib.adai.washington.edu/instruments/
Michigan Alcoholism Screening Test MAST	http://www.projectcork.org/clinical_tools/index.html
Drug Abuse Screening Test DAST	http://www.projectcork.org/clinical_tools/index.html
Dartmouth Assessment Lifestyle Inventory DALI	http://lib.adai.washington.edu/instruments/
Alcohol Use Disorder Identification Test AUDIT and variations	http://lib.adai.washington.edu/instruments/
Alcohol, Smoking, Substance Involvement Screening Tool ASSIST	http://lib.adai.washington.edu/instruments/
UNCOPE	http://lib.adai.washington.edu/instruments/
CRAFFT	http://lib.adai.washington.edu/instruments/
Clinical Institute Withdrawal Assessment for Alcohol CIWA-Ar	http://lib.adai.washington.edu/instruments/

Mental Health	
Mental Status Exam MSE	http://www.psychpage.com/learning/library/assess/mse.htm
Mini-Mental Status Exam MMSE	http://www.minimental.com
Brief Symptom Inventory BSI	http://www.pearsonassessments.com/
Symptom Checklist SCL-90R	http://www.pearsonassessments.com/
Brief Psychiatric Rating Scale (BPRS)	http://www.priory.com/psych/bprs.htm
Mental Health Screening Form III	http://www.asapnys.org/resources.html